WWWP CASE MANAGEMENT CLIENT ASSESSMENT AND PLAN

The client, local WWWP coordinator, or health care provider may complete client information. This form can be completed at enrollment, at time of notification of abnormal screening, at time of diagnosis, and as the client reports a change.

Client name _____ The following information recorded on _____ (date) by_____ (self or name and title of health care provider or local WWWP coordinator) in person ____or via telephone ____.

Please indicate the barriers that may prevent you from receiving Screening, Diagnostic and Treatment:

____Transportation to your appointment
____Child or family care
____Leaving work/ Work schedule
____Loss of employment
____Lack of money
____Lack of insurance
____Communication barriers/Language translation
____Cultural concerns
____Sexual concerns
____Reaction of family or significant other
____Disabilities
____Need more information as to what services are covered by WWWP
____Need more information on the services provided
____Concerns as to how to obtain information on the results
____Concerns about confidentiality
____Discomfort or pain related to the procedure
____Fear of cancer, change in body, loss of intimacy
____Overwhelmed by information
____Lack of energy / profound feelings of anger, sadness
____Other (please describe)_____
____Refused by client

Please notify the local WWWP coordinator if you have a change in the above barriers.

WWWP Local Coordinator Notes

Continue on back of form. Include date of each encounter or action related to case management and essential support services, describe barriers, use of the essential treatment plan, client specific plan and actions in relation to overcoming barriers, and signature for each note.

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